

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/19/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for 2 State hospital complaint investigations.</p> <p>Complaint: #IN00120272 Substantiated-no deficiencies cited #IN00117477 Unsubstantiated- lack of sufficient evidence.</p> <p>Survey Date: 08/19/13</p> <p>Facility # 005002</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Methodist Hospitals, Inc., is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/10/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE